This information is provided as guidance for units that are scheduled to deploy to the National Training Center.

Everything is referenced from current doctrine and areas of emphasis are highlighted. The Individual Medical Trainer Wolf24 addresses specific issues and items of concern.

Mission and Functions

The mission and functions of unit-level (Echelon I) HSS elements are --

- Prevention of disease and illness through applied PVNTMED programs.
- Acquisition and immediate treatment of the sick, injured, and wounded.
- Clinical stabilization of the critically injured or wounded.
- Provision for routine medical care (sick call) and the immediate RTD of soldiers "fit to fight."

Echelon I HSS is reinforced by Echelon II and III HSS; each providing increased support to the patient. During lulls in operations, unit-level medical personnel conduct tactical and technical proficiency training. When required, they provide instructions to nonmedical personnel in self aid/buddy aid (first aid), CLS procedures, patient evacuation, field sanitation, and personal hygiene.

Unit level HSS within the division is provided by organic medical elements assigned to combat battalions, selected CS battalions, division headquarters, CAB headquarters, and the DIVARTY headquarters. Their purpose is to provide direct HSS to subordinate elements of the organization. Medical platoons or sections in the following organizations/units provide this support:

- Armored Battalion-Medical Platoon, HHC.
- Mechanized Infantry Battalion-Medical Platoon, HHC.
- Infantry Battalion-Medical Platoon, HHC.
- **Field Artillery Battalion (Direct Support)**, DIVARTY-Medical Section, Headquarters and Headquarters and Service Battery (HHS).
- Infantry Division (Light)-Medical Section, HHC.

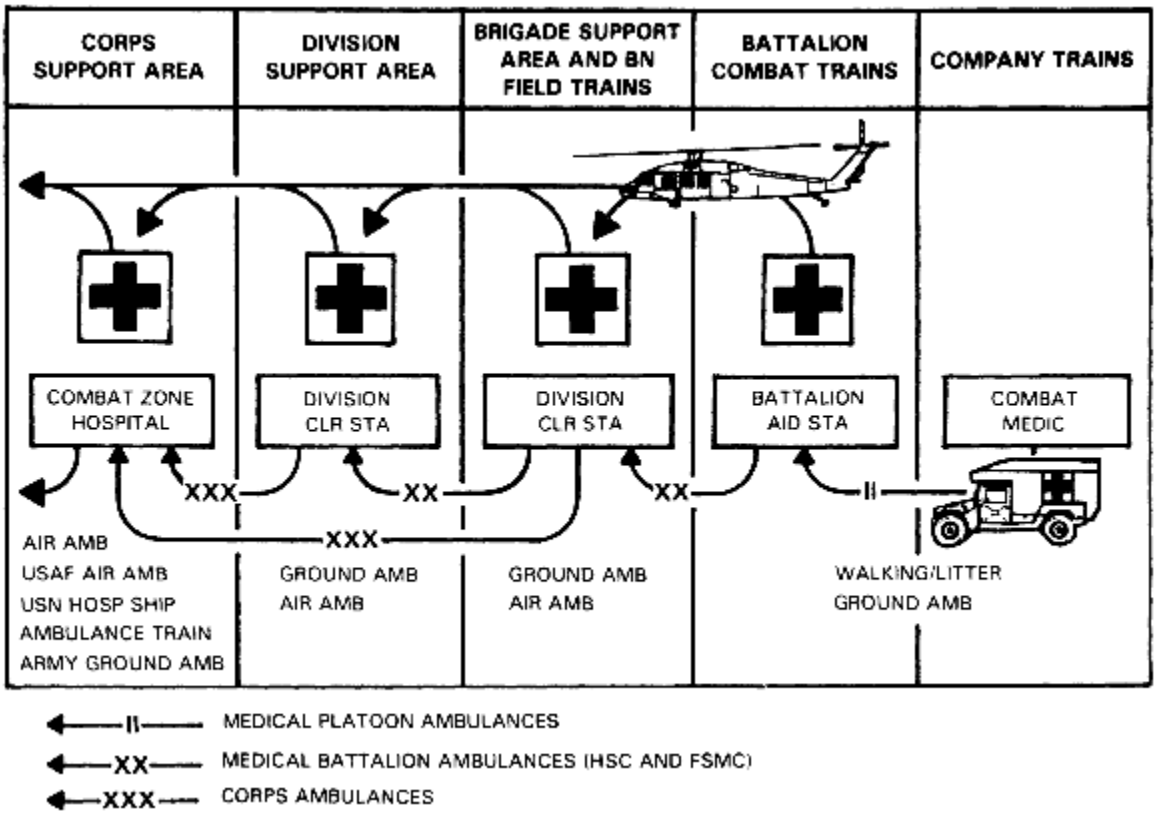
The organic medical platoons and sections above are modular in design, and operate from mobile treatment shelters. They have organic vehicles that provide maximum deployability and mission responsiveness.

Medical Evacuation

Optimum patient care and treatment is dependent upon an evacuation system that provides a continuous movement of patients. Medical evacuation is the process of moving patients from the point of injury or illness to an MTF or between MTFs. Each stop in the process is to provide medical treatment to enhance the patient's early RTD or to stabilize him for further evacuation. **The responsibility for patient evacuation rests with the level of HSS to which the patient is to be evacuated**. Ambulances go forward, pick up patients, and move them to the supporting MTFs.

(1) Ambulance teams of the medical platoon evacuate patients from the company aid post or patient collecting points to the BAS. For the FA Battalion, the firing battery must identify non-standard CASEVAC vehicles to assist in this task. Presently there is only one M997/FLA in the Paladin battalion.

(2) Ambulance squads of the FSMC evacuate patients from the BAS to the DCS.



An ambulance shuttle system may be set up between the FSMC DCS and the BAS. An AXP is established so that ambulances are moving forward as others move rearward; thus enabling a continuous rearward evacuation flow, while decreasing ambulance turnaround time. Patients are evacuated no further to the rear than their conditions require.

Medical Supply

a. The medical platoon maintains a 2-day (48-hour) stockage of medical supplies. Normal medical resupply of the platoon is performed by the DMSO through backhaul or in coordination with the movement control office (MCO). Medical resupply may also be by Reconfigured Class VIII packages (PUSH packages) throughput from the forward MEDSOM/MEDLOG battalion located in the corps support area.

b. In a tactical environment, the emergency medical resupply (ambulance backhaul) system is used. In this environment, medical supplies are obtained informally and as rapidly as possible, using any available medical transportation assets. The medical platoon submits supply requests to the supporting FSMC, who in turn fills requests and

ships supplies forward. Request for items not available at the FSMC are forwarded to the DMSO; the request is filled from division stocks and shipped to the requester by the most expedient means available. Air ambulances from corps and ground ambulances from the DISCOM transport medical supplies directly to BASs. Ambulances of the medical platoon perform class VIII resupply of combat medics.

MEDICAL SECTIONS AND SPECIAL PURPOSE MEDICAL PLATOONS

Medical Section, Direct Support Field Artillery Battalion

This section is organic to the Headquarters and Headquarters Support Company (HHS) of the direct support (DS) FA battalions. Personnel staffing for this medical section includes a section leader/PA, a section sergeant/EMT NCO, two medical specialists, and three combat medics (battery aidmen). The authorization for personnel will depend on current MTOE.

Section Leader/Physicians' Assistant. The PA is an advisor to the battalion commander and his staff. He is the primary medical care provider for the battalion and supervises all activities of the medical section. The PA is trained in ATM procedures and works under the clinical supervision of a medical officer. He is responsible to the supervising physician for all treatment provided by medical personnel of the section. His specific duties include --

- Establishing and operating the BAS.
- Planning and supervising unit-level HSS and coordinating division-level HSS for the battalion.
- Treating, within his ability, patients reporting to him.
- Referring patients who require treatment beyond his capability to the supervising physician.
- Providing initial resuscitation (ATM) for the wounded.
- Training medical personnel and CLS in emergency medical procedures.

Section Sergeant. The section sergeant, who is also an EMT NCO, assists the medical officer in accomplishing his duties and supervises the medical specialists. He prepares reports, requests general and medical supplies, maintains supply economy procedures, and maintains authorized stockage level of expendable supplies.-This NCO also performs triage and ATM procedures in the care of trauma and NBC-insulted patients, and care and management of battle fatigue patients. He also performs routine patient care and NBC detection procedures. His duties further include --

- Establishing and operating the battalion aid station.
- Maintaining the patient accountability/casualty reporting system.
- Maintaining medical equipment sets.
- Conducting tactical and technical proficiency training for subordinate members of the section.
- Conducting sanitation inspections of troop living areas, food service areas, waste disposal areas, and potable water distribution points and equipment.

Medical Specialists. These specialists assist the section sergeant in accomplishing his duties. They perform triage and EMT. Their specific duties include --

*Erecting and breaking down field medical shelter systems, to include chemical/biological protective shelters.

- Performing patient care.
- Initiating patient records (FMC).
- Maintaining the patient daily disposition log.
- Operating and maintaining assigned vehicle, tactical radio, and power generation equipment. (Also may serve as a member on the battery field sanitation team.)

Combat Medics. Combat medics are allocated to a DS FA battalion on the basis of one to each firing battery. The duties and functions of combat medics are described in paragraph. To foster good interpersonal relations and morale of combat troops, combat medics are attached to maneuver companies (firing battery) on a continuing basis. However, during lulls in combat operations, they should return to the medical platoon for consultation and proficiency training. Functions of combat medics are as follows:

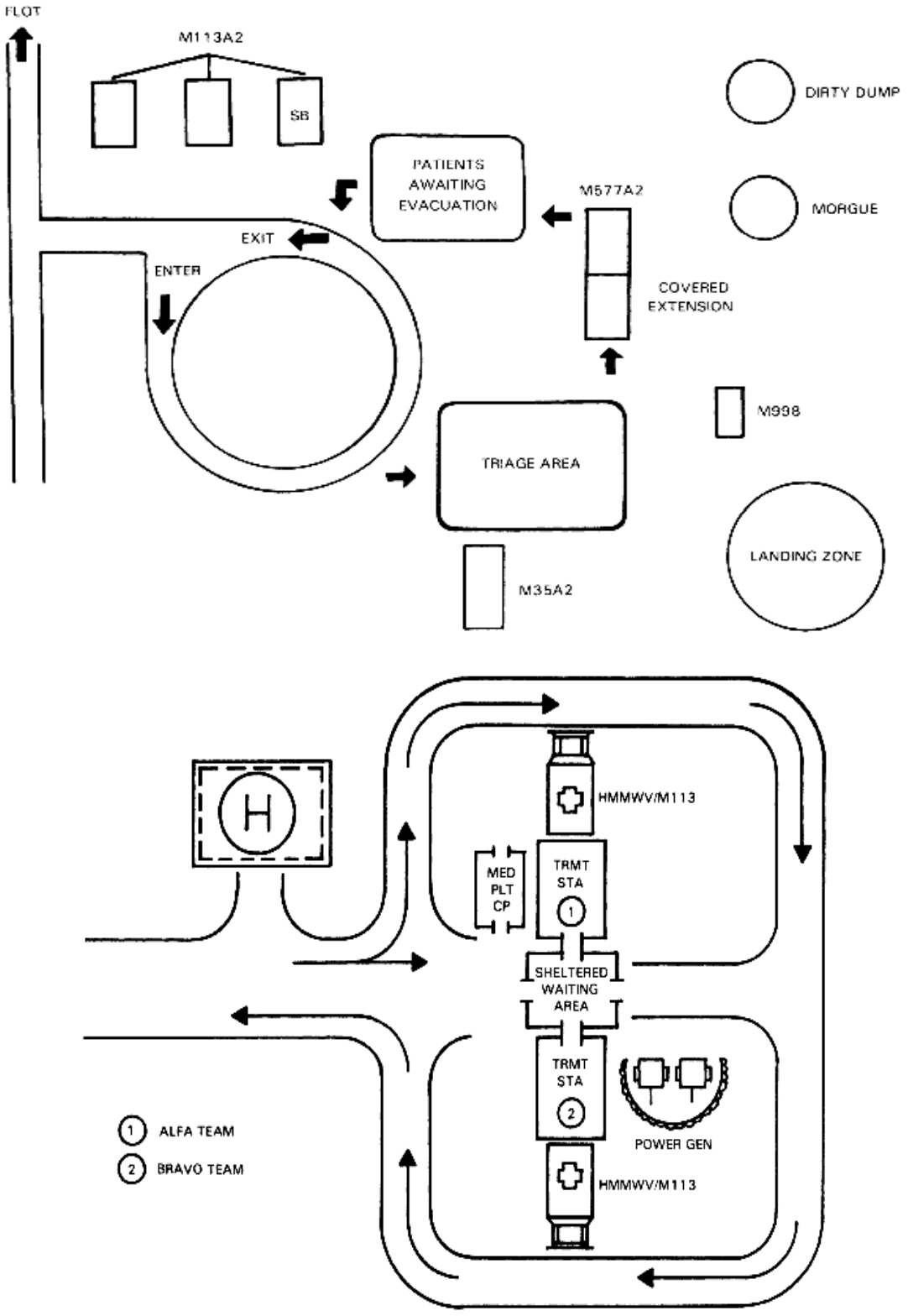
- Performs triage and EMT for the sick and wounded.
- Arranges medical evacuation for litter patients and directs ambulatory patients to patient collecting points or to the BAS.
- Initiates the FMC for the sick and wounded and, as time permits, prepares an FMC on deceased personnel.
- Screens, evaluates, and treats, within his capabilities, those patients suffering minor illnesses and injuries. He RTD those patients requiring no further attention.
- Keeps the company commander and the battalion surgeon (or the PA in the absence of the surgeon) informed on matters pertaining to the health and welfare of the troops.
- Maintains sufficient quantities of medical supplies to support the tactical situation.
- Serves as a member of the unit field sanitation team. In this capacity, he advises the commander and supervises unit personnel on matters of personal hygiene and field sanitation (FM 21-10-1).

Employment. The medical section establishes a BAS IAW the battalion SOP and provides unit-level HSS. The BAS is normally located within the Combat Artillery Trains.

(1) The section employs a HMMWV treatment vehicle, a cargo trailer, and two medical equipment sets: one MES Trauma treatment set (2) and one MES general sick call (2) set.

(2) For communications, the section employs a telephone set (TA 312/PT) and is deployed in the HHS wire communications net. It also employs an FM tactical radio and is deployed in the net designated by the BN SOI. This section also has access to the supporting medical company's tactical operations net to request division-level HSS.

Operations set-up. Layout of a battalion aid station (heavy); these are equally applicable to the FA BAS.



This is just an example of how to deploy the BAS equipment. Use and employment will be METT-TC based on offensive or defensive posture. The BAS placement within the CAT should be part of the SOP.

The FA Battalion will not heavy equipment (tracked) as part of its MTOE, but supporting medical assets may have M113's or M997. The FA BAS will normally have one 5-ton and several M998 cargo vehicles. Those vehicles should be configured (load plans) for both stationary treatment and tailgate medicine.

Medical Evacuation. **The FA battalions (DS) medical section has limited medical evacuation assets. Prior planning and coordination with the supporting medical company in the BSA can assist in the evacuation of patients to and from the BAS.**

The following is taken from **FM 3-09.70 TTP for M109A6 Howitzer (Paladin) Operations** dated August 2000. It presents a dramatic change in the number of personnel and vehicles within the medical section. It will allow the medical section to better support the battalion, firing batteries and expedite casualty evacuation.

CASUALTY EVACUATION

Special considerations must be given to casualty evacuation in a Paladin battalion to reinforce responsiveness and dispersion. For a battalion to administer proper care to its wounded, the following medical assets are needed for routine evacuation.

MEDICAL TREATMENT TEAM

This team includes an emergency treatment NCO and two medical specialists. Equipment includes two HMMWVs, one secure FM radio, two chemically and biologically protected shelter systems, and medical equipment sets for field trauma, sick call, chemical agent decontamination, and chemical agent treatment.

AMBULANCE TEAMS (change from previous doctrine)

This team consists of one evacuation NCO and an ambulance driver per ambulance. It supports the medical treatment team in the firing batteries and battalion in medical evacuation. Equipment includes four HMMWV ambulances with FM radios, and secure GPSs.

COMBAT MEDIC SQUAD (change from previous doctrine)

This squad consists of six combat medical specialists. One combat medic is allocated per firing platoon. Each medic carries a surgical kit.

MASS CASUALTIES

For mass casualty evacuation, the battalion must rely on its combat lifesavers and organic transport capabilities in addition to its medical section personnel and medical transport capabilities. For planning purposes, a cargo HMMWV can transport up to five litter casualties and a 2 1/2-ton truck or 5- ton truck can transport up to 12 casualties (see FM 8-10-6, *Medical*

Evacuation in a Theater of Operations TTP). Battalion or battery TSOPs should address a standard layout for a casualty collection point at the BAS and battery or platoon. Litter teams need to be identified and trained at every separate element within the battalion. Combat medics, combat lifesavers, and litter teams must conduct rehearsals to ensure they can effectively collect, provide aid, and transport casualties.

The battalion addresses, in the FASP, those actions to be taken in the event of mass casualties. If only one battery or platoon is hit, the closest battery provides combat lifesavers and evacuation vehicles. If two batteries are hit, the surviving battery and the combat trains provide assistance. When two or three batteries are hit, mass casualty assistance will likely have to come from brigade or task force assets. In any mass causality event, the battalion must resist diverting medical personnel from the BSA. The limited number of medical personnel should remain at the combat trains providing C2, through the combat trains/ALOC, and casualty assistance in a protected environment.

TRAINING PROCEDURES GUIDE

The following guide is provided to help you design preparing, presenting, practicing, and performing in preparation for deployment.

Planning

- Review command guidance, unit missions, and FM 25-100.
    - Review the training objective (task, conditions, and standards).
    - Determine the soldiers or units to be trained.
    - Determine the place and time of training.
    - Determine the resources and facilities available.
    - Consult training references.
    - Review coordinating instructions and special considerations.
- Use backward planning.
    - Determine what, where, how, and when the training will take place.
    - List all necessary actions to prepare for training.
    - Estimate the time needed for each action.
    - Arrange the necessary actions in reverse order, beginning with the last action and working back to the first.
    - Schedule the necessary actions.
- Develop the training outline.
    - Write training statement based on the training objective.
    - Develop a caution statement (personnel or equipment hazards or security classification).
    - Select the presentation method (demonstration, demonstration with practice, conference, lecture, or combination of two or more).

Preparing

- Prepare yourself.
    - Know how to perform the task being trained.
    - Know how to train others to perform the task.
- Prepare the soldiers.
    - Identify the soldiers or units to be trained.
    - Motivate the soldiers.
    - Announce the training.
    - Train any prerequisite tasks first.
- Prepare the equipment, facilities, and materials.
    - Reserve, request, and requisition.
    - Receive equipment and materials before rehearsals.
    - Operate the equipment to become familiar with it and to check it for completeness and spare parts.
- Prepare the training support personnel.
    - Ensure they understand their support roles.
    - Ensure they know their role as evaluators.
    - Ensure they are equipped and prepared to perform.

Presenting

- Provide enough information to permit practice.
- Give information that motivates.
- Present information that allows transfer of training, if applicable.
- Tell the soldiers exact task, conditions, and standard.

Practicing

- Train the tasks step by step.
    - Give the soldiers a basic knowledge of, and familiarity with, each task.
    - Build confidence.
- Train the tasks to standard.
    - Improve soldier performance to meet the training objective standards.
    - Use sustainment training.
- Train the tasks in realistic settings.
    - Add realism to increase the challenge.
    - Train to achieve time requirements.
    - Use sustainment training.

Performing

- Evaluate performance with a post training check, by sampling, by on-the job observation, by test or evaluation by higher headquarters, or by internal evaluation.
- Record and report the results.

COMBAT TRAINING CENTERS LESSONS LEARNED. The following is taken directly from FM 8-10-4, Appendix G. These are just some of the issues that are seen on a regular basis at the National Training Center. Properly addressing these prior to the NTC deployment will better prepare your section and increase the training potential.

- Ensure that all medical equipment sets are complete. Request medical items (controlled/ accountable drugs) at least 2 months before rotation.

- Ensure that all TOE equipment is on hand and in working order. Verify the status and availability of all equipment at least 2 months before rotation. Have all equipment serviced/ repaired as needed to be 100 percent operational.

  Bring everything with you. *Train as you fight-fight as you train.*

- Establish resupply support (including Class VIII) for items needed during the training period. Prepare signature cards for request and receipt of supplies. Arrange for support from HSS elements/hospital for patients requiring care beyond your unit capabilities. Do not wait until you get to the NTC to address this issue. Historically, the class VIII flow does not start until TD-7.
- Prepare for prevention of heat injury casualties. EXAMPLE: Ensure water consumption policies are established and monitored. Personnel must drink water frequently. Consider ways to protect IV fluids from the heat/cold.

- Prepare overlays showing BAS, AXP, PCP, and split treatment team locations, if maps of the operational area are available. Medical-Battle Tracking will expedite patient treatment and evacuation.

- Prepare **OPORD, SOP, and HSSPLAN** for medical platoon/section. Prepare input for inclusion in higher command and support elements' OPORD, SOP, and HSSPLAN.
- Prepare unit for mission through unit training at home station; begin training METL upon notification of rotation if not already in force.

- Medical platoon leadership not preparing/reviewing and forwarding feeder reports in a timely manner. Get the S-1 involved in the casualty information collection process.

- Early request for nonmedical vehicle support in movement of mass casualties was not supported on a timely basis**.** Clearly identify those vehicles that will be used as nonstandard CASEVAC platforms during Battalion CSS rehearsals prior to the battle.

- Resupply system for medical supplies inadequately planned for and ineffective. Medical Platoons/Sections must establish Class VIII/Logistical support prior to deployment with their FSB. Do not wait until you get to the NTC to "work it out".

- Mass casualty plans need to be well developed, coordinated with supporting units/sections, documented in an SOP, and rehearsed during training.
- The medical platoon leader is a member of the staff and should be accepted as such. He should attend mission briefings and have the responsibility for medical planning and, in turn, brief the medical support plan. When the medical platoon leader is not included in

the planning, this can result in missed coordination when the taskings are finally passed to the medical platoon.

- During the planning phase, the battalion needs to --
    - Develop a plan to access, handle, evacuate, and treat NBC casualties.
    - Look at methods for performing MEDEVAC missions.
    - Ensure the assets required for mission accomplishment are included.
    - Provide a plan for including the medics on the mission.

- An effective SOP for casualty evacuation; soldiers understanding of first aid procedures; and leaders awareness of the combat and field trains locations are instrumental in preventing soldiers dying of wounds.
- Coordination of medical evacuation operations must be emphasized within the battalion. The battalion needs to standardize procedures for designating patient collecting points and the hand over of patients to the medical company.
- Units need to triage/prioritize casualties for treatment and evacuation. When this is not done, soldiers with superficial wounds are treated before those with life-threatening wounds. A unit SOP for casualty evacuation can consolidate or coordinate the effort. The absence of sufficient medics and trained combat lifesavers can intensify the problem.
- When casualties were taken on the battlefield, self-aid or buddy aid was rarely administered. When aid and litter teams were identified, soldiers were uncertain of their duties/responsibilities as aid/litter team members. There was no plan or system in place to ensure casualties were treated and evacuated to the patient collecting points. Once at the patient collecting point, there was no triage during evacuation. If the company had two patient collecting points, casualties were evacuated to the other collecting point without regard to the type and extent of injury. On several occasions, the unit did not know that their casualties were never evacuated from the company patient collecting point. This resulted in soldiers dying of wounds.
- The medics in the line batteries did not establish and maintain platoon and company patient collecting points effectively. The medics did not consistently organize collecting points to facilitate rapid evacuation of patients. Sites for LZ/PZs for MEDEVAC operations were not selected consistently or effectively. The lack of triage and treatment of patients resulted in several patients being designated as died of wounds. Though the technical proficiency was present, the ability to apply those skills to a tactical environment was not always evident.

- The need to brief CSS personnel and rehearse their functions is just as critical as the rehearsals conducted by maneuver units. Route and convoy briefings, patient evacuation practice, and security reaction plans must all be briefed and practiced. Ensure rehearsals are conducted to the lowest possible level and for all probable contingencies in preparation for all operations.
- Classes (OPD/NCOPD) need to be taught which explain in detail the HSS system of a light infantry division. The battalion PA or personnel from the medical battalion should be considered as instructors. All FTXs need to incorporate HSS play in the scenarios, from squad through brigade level.
- The medical platoon leader needs to receive training from the medical battalion to include participation in their FTXs/CPXs. The battalion should give him time to learn his job and not overwhelm him with additional duties.
- The battalion medical platoon, in conjunction with the medical company, should war-game medical evacuation procedures to clearly define responsibilities and refine support requirements. This war-gaming can be conducted using the LOGMOD/ADMIN GTAs, various terrain models, and various missions, which the battalion can receive.

- Practice using air ambulances to include support planning, LZ site selection and preparation, defense, and communications.

- There needs to be cross-training to cover those MOSs that are one deep in the unit. Reassignments or injuries may keep these personnel from deploying. They may become incapacitated while in the field. Their absence will cause a decline in the quality of care being provided.
- Medical evacuation should have a dedicated radio frequency; the medical company should monitor it. If the SOI does not list a frequency, then employ a spare.
- The battalion aid station must establish and maintain communication with the supporting medical company at all times. When contact is broken, the platoon leader must hastily rectify the situation. Presently, calls go through the field trains, brigade tactical operations center, an FASCO before being received by the supporting medical company. This caused a waste of time delay in response, and ties up communication net.
- Combat lifesavers are an integral facet the HSS doctrine. They place life-sustaining skills within each crew/team/section. With a minimal number of medical personnel assigned in the line units, the combat lifesavers and their equipment, add the required dimension of care that can decrease the number of died of wounds. In the mass casualty situations that occurred during this rotation, their valued training was not present.

Rules of Engagement

The following is an extract from the NTC Rules of Engagement. These are the most current CSS and Safety issues that are of specific interest to the medical platoon/section.

The NTC battlefield provides brigades challenging and realistic training on all aspects of logistical operations. Time constraints and reporting procedures regarding personnel and vehicle reconstitution are closely monitored in order to replicate actual combat. This chapter will discuss procedures for CSS operations that can be expected to be conducted throughout a NTC rotation.

MILES and NBC Casualty Cards

There are five types of casualty cards as listed below:

Return To Duty (RTD). These soldiers require only self/buddy aid and are not required to be evacuated to a medical treatment facility. These soldiers are considered casualties and will not continue to fight, but they may assist fellow casualties

Walking. Most are routine precedence casualties and, IAW the MILES casualty card, can walk, talk, and/or provide assistance to the unit after first aid is completed. Wounded will be tactically evacuated IAW the unit's SOP and/or OPORDs. They must be evacuated to a medical treatment facility (Level I Aid Station). When being transported, wounded soldiers can remain seated.

Litter (L). Litter casualties will be carried on a standard or field expedient litter only. Litter casualties will be either "**Priority**" or "**Urgen**t" as printed on their MILES casualty cards. The litter casualty must be evacuated to a medical treatment facility (Level II Aid Station). . **The only difference between a litter urgent and a litter priority patient is the available time to evaluate the casualty.**

Killed In Action (KIA). This casualty must be evacuated to the appropriate collection point designated IAW unit's graves registration (GRREG) SOP. KIAs will remain dead for five hours after each respective company and/or separate platoon evacuates the last KIA to the appropriate collection point. Before being reconstituted and sent back to their units, the OC will verify the DA Form 1156 is completed. KIAs will not be rekeyed if the unit does not report these losses to their higher headquarters.

Any of the five MILES casualty cards may also be an NBC casualty card. Any individual taking improper protective measures will be assessed as an NBC casualty.

Medical Care Echelon Levels

1. Echelon I (Level I) Medical Care. The first level of medical care a soldier receives is provided at this echelon. It includes the following:

a. Self-aid/Buddy aid.
b. Combat Lifesaver.
c. Combat Medic.
d. Primary Care Provider. The physician and the physician's assistant in a treatment squad (aid station ATLS team) are trained and equipped to provide advanced trauma management (ATM) to the battlefield casualty.

A primary care provider must evaluate all MILES casualty precedence categories, with exception of routine, and DD Form 1380 completed as required

2. Echelon II (Level II) Medical Care. These functions are performed by medical companies organic to:

a. Support Battalions of separate maneuver Brigades
b. Support Squadrons of ACR's.
c. Support Battalions of DISCOM's
d. Medical Battalions (area support and corps)

Casualty Evacuation

1. **Time Requirements**. Time required for evacuation begins at the time the casualty is assessed.

2. **Casualties**. Casualties will be loaded IAW Chapter 10, FM 8-10-6. Litter patients will ride seated after being properly loaded and secured when non-medical vehicles are used for casualty transport and medical evacuation. Units will not exceed the casualty carrying capacity of the evacuation vehicle. Litters and all equipment required to properly transport the casualty will accompany casualties through the evacuation. Upon arrival at the medical facility, litter patients will be properly configured and secured prior to the casualty being downloaded from the vehicle

3. **Aviation Casualty Evacuation**. Casualties may also be evacuated via aviation assets, either medical or non-medical. The casualties must physically be loaded on those assets dedicated to this operation.

4. **Died Of Wounds**. Walking wounded or litter casualties, will be declared "Died of Wounds" (DOW) when:

a. The casualty receives improper medical treatment.

b. Improper transportation methods are utilized in an evacuation phase.

c. Casualty evacuation times are not met.

d. Casualty arrives at a medical treatment facility having lost his/her MILES casualty card or without a DD Form 1380, Field Medical Card. This assessment will be made only by the OC at the respective medical treatment facility. The DD 1380 will be annotated and accompany the DOW to the designated collection point.

e. Casualty is a failure to evacuate (FTE) if he remains at the point of injury and never receives treatment or evacuation. These personnel are considered died of wounds (DOW).

Casualty Precedence. All casualty evacuation times are based on precedence (Urgent, Priority, and Routine). The time allowed for evacuation starts at the point of injury and depends on the type of initial care provided. Times are not cumulative. An urgent casualty that receives combat medic, combat lifesaver, and buddy aid at point of injury still has only two hours for evacuation to Level I care.

a. Evacuation to Level I primary care provider (BAS):

Urgent: If treated by a combat medic at the point of injury the casualty has **2** hours for evacuation. If treated by a combat lifesaver, the casualty has **1.5** hours for evacuation. If treated by self/buddy aid, the casualty has **1** hour for evacuation.

Priority: If treated by a combat medic at the point of injury the casualty has **4** hours for evacuation. If treated by a combat lifesaver, the casualty has **3** hours for evacuation. If treated by self/buddy aid, the casualty has **2** hours for evacuation.

Routine: If treated by a combat medic at the point of injury the casualty has **12** hours for evacuation. If treated by a combat lifesaver, the casualty has **8** hours for evacuation. If treated by self/buddy aid, the casualty has **6** hours for evacuation. After proper treatment at Level I, routine casualties are RTD.

b. Evacuation from Level I primary care provider (BAS) to Level II (BSA)

Urgent: After proper treatment at Level I, the casualty has an additional **2** hours for evacuation to Level II care.

Priority: After proper treatment at Level I, the casualty has an additional 4 hours for evacuation to Level II care.

Routine: Routine casualties are RTD after proper treatment at Level I and do not require evacuation to Level II.

Unit medics will fill out DD Form 1380, Field Medical Card, IAW FM 8-10-6, Medical Evacuation in a Theater of Operations, for all casualties requiring evacuation.

Combat Lifesavers: Units must provide their OCs with a list of current combat lifesavers prior to departing from the RUBA. OCs will inspect the combat lifesaver bags during RSOI. Combat lifesavers must receive class VIII resupply through normal channels.
Insert hyperlink current combat lifesaver bag inventory

Personnel Reconstitution.

After being released from the medical treatment facility or hasty GRREG Point, as appropriate, the individual will be taken to the unit's BDE Personnel Section holding area. The Bde S-1 or representative will control the individuals and take them to the OC conducting reconstitution. All unit casualties (except RTDs) will be processed through the OC conducting personnel reconstitution. For casualties not declared DOWs or KIAs, after verifying that medical treatment has been rendered, and the DA Form 1156 is completed, the OC will reactivate the individual's MWLD/PDD harness and allow these personnel to return to their unit.

DOWs. After verifying, the MILES card is annotated with DOW, the OC will require the unit to transport these personnel back to the GRREG Point located in the BSA. After processing through the BSA GRREG Point, DOWs will remain with the unit field trains in the BSA until the unit's next day scheduled LOGPAC or **24 hours**, whichever comes first.

Medical vehicles and personnel that have been assessed as casualties will continue to monitor radio traffic in case there is a real world emergency so they may move freely to the scene to render assistance.

Class VIII. Units will provide a complete listing of all Class VIII items on hand, by medical chest, to the medical OC as required. Units are further required to designate a location at each medical treatment facility to store medical supplies, which are expended during the treatment of simulated casualties. As medical supplies are expended they will be placed in this location under the control of the medical OC. As medical supplies are regenerated through the Class VIII resupply system, the appropriate medical supplies will be moved under OC control from the storage location back into unit stocks.

Safety

General Information

Rigorous Training. The National Training Center will expose your soldiers to the most rigorous and realistic training found in the world.
Rigorous Desert Environment: Surface temperatures in the Mojave Desert reach 125 degrees Fahrenheit during summer months. Winter month temperatures fall below freezing for periods lasting over 48 hours. Heavy rains in the training area and runoff from adjacent mountain ranges rapidly turn dry streambeds and wades into free flowing rivers. Windstorms occur year round. The highest wind velocity recorded at the NTC is over 100 miles per hour. Added to this climate is a potentially dangerous wildlife population

Heat Injuries

Heat Injury is the number one injury resulting in emergency medical evacuation of soldiers. Insufficient water intake is the largest single cause of heat injuries.
Know the hazards and Risk reduction measures for Dehydration and Heat Casualties.

Cold Weather Injuries

Extreme weather conditions and severe temperature fluctuations occur during winter months. High winds will produce a significant wind chill factor. Know the hazards and Risk reduction measures for Frost Bite and Hypothermia.

Wildlife

Poisonous snakes, spiders, scorpions, insects, and large wild animals indigenous to the Mojave Desert are abundant on the reservation. Bobcats and coyotes are found on all parts of the reservation and roam freely in the cantonment area.

Know the hazards and Risk reduction measures for dealing and handling with Coyotes & Bobcats, Desert Tortoise, and Poisonous Snakes.

Four species of poisonous snakes have been found on Fort Irwin: Western Diamondback, Speckled Rattlesnake, Sidewinder, and the Mojave Green Rattlesnake. The Mojave Green Rattlesnake is the most poisonous snake in North America.

Arachnids (Scorpions and Spiders). Scorpions and several species of poisonous spiders are found throughout the desert. Some species of spiders found on NTC are potentially dangerous to

humans. The venom of a Recluse Spider, as with many insects, may be life threatening if a bitten soldier has an allergic reaction to the insect venom

NTC MEDEVAC Helicopter Procedures

Rotational units are expected to evacuate casualties IAW their unit's SOP. The rotational unit chain of command is responsible for insuring that all soldiers know the MEDEVAC frequencies and procedures. The 247th MEDEVAC Detachment is available to all units training at the NTC for **ACTUAL MEDICAL EMERGENCIES**. Requests for emergency medical evacuation of personnel to Weed Army Hospital by **MEDEVAC HELICOPTER** should be called directly to Fort Irwin Range Control on frequency 38.90 (Non-Secure), VHF 126.20 or UHF 241.00 using the standard 9-line MEDEVAC request format. OCs are trained in MEDEVAC procedures and will assist units experiencing difficulty requesting a MEDEVAC.

When Air/Ground communications are established, the pilot will require the following information from the ground LZ:

(1) Size of PZ
(2) OBSTACLES (wire, antennas, etc.)
(3) Wind direction and approximate velocity.
(4) Slope of the terrain.

Personnel not required for the MEDEVAC will relocate or avoid coming within 500 meters of the MEDEVAC site and continue training and will resume training as soon as MEDEVAC is completed

Table: 12-16 9 Line MEDEVAC Request	
LINE 1	Location of pick up site (Grid Coordinate).
LINE 2	Radio frequency, your call sign and suffix.
LINE 3	Number of patients by precedence: 1 – Urgent 2 – Priority 3 - Routine
LINE 4	Special equipment required *Request a "DOCTOR" accompany the MEDEVAC if a fatality has occurred or is believed to be imminent.
LINE 5	Number of patients by type
LINE 6	Number and type of wounded, injury or illness.
LINE 7	Method of marking pickup site (LZ).
LINE 8	Patients nationality and status (Military/Civilian)
LINE 9	Terrain description.

The following websites are an excellent source of information:
For FM, TM, GTA, etc….
General Dennis J. Reimer Training and Doctrine Digital Library

For Lessons learned and links to the Combat Training Centers
Combat Training Center Issues

AMEDD issues and combat development input
Welcome to Enterprise Consultancy webpage

General information and links
The United States Army Homepage

MTOE information and authorization
www.usafmsardd.army.mil

POC this information is SFC Fermin / Wolf 24 at 760-380-5523
E-mail at: sigaro64@earthlink.net